NC DIVISION OF MH/DD/SAS
Residential Treatment Medicaid Services Audit
FY 2009/2010

AUDITOR GUIDELINES

- If the provider identified documentation deficiencies and paid back the event to Medicaid prior to the date the list of records to be audited was sent to the provider, do not include the event in the audit.
    - Enter "8" in each rating box on the tool, and write "Exclude" on the top of the tool. DO NOT DISCARD.
    - Explain in the comments section of the audit form why the "8" ratings were used and attach a copy of documentation confirming the date and amount of the payback.
    - Replace the excluded tool with the first/next numbered tool from the alternates (start with #11). Alternate tools *must be used in order*.

MEDICAID AUDIT QUESTIONS

Q1 – Service Authorization:

- All services must be authorized by ValueOptions (VO)
- If the provider does not have evidence of authorization from VO, check for service authorization that covers the date of service being reviewed on the spreadsheet provided by VO. (The spreadsheet will be available on laptops at the team leader table.)
- **Ratings:**
    - If authorization is present, rate Q1a = "4".
    - If no authorization**,** rate Q1a = "0".
    - If Q1a is rated "0", enter the dates in Q1b. **FROM is the first date when there was no valid authorization, or 7/1/09; TO is the last date there was no valid authorization or the date of the audit**, if there is still no authorization.

Q2 – Service Order

- **Service Orders for Level III, Level IV:**
    - Appropriate service has been ordered. **The level of residential treatment service needs to be identified in the body of the PCP to be ordered via signature on the PCP.** Separate service order forms are not acceptable.
    - A service order may not be obtained (signature on the PCP) before the PCP is completed. **Service order signatures dated prior to the PCP date are not acceptable as service orders.**
    - Medicaid-funded services must be ordered by a licensed MD or DO, a licensed psychologist, a licensed nurse practitioner or a licensed physician's assistant.

        - The signature must be handwritten by the signatory. A stamped signature is only acceptable with a verified Americans with Disabilities Act (ADA) exception.
    - When the PCP is reviewed/updated, but no new service is the result, the signature for the service order is not required unless it is time for the annual review of medical necessity.
    - Order is signed on or before the date of service.
    - **Multiple levels of service may not be ordered / listed for the same time period in the PCP.** If they are, the only valid order is the one for the service level the child was actually admitted to.
    - **A new service order must be obtained at any time a child changes the level of residential treatment to which they are admitted, even if returning to a former level.**
    - Example: If a child goes from Level III to Level II, a Level II order is needed at the time of the change. If that same child then goes back to Level III later, a NEW order is needed for Level III.
- **Ratings:**
    - If service order is present, rate Q2a = "4".
    - If no service order**,** rate Q2a = "0".
    - If Q2a is rated "0", enter the dates in Q2b. **FROM is the date the PCP was written, or 7/1/09; TO is the last date there was no valid service order or the date of the audit**, if there is still no authorization.

Q3 – PCP is Current:

- The individualized PCP shall begin at admission and shall be updated/revised:
    - If the needs of the person have changed (i.e., new service is being requested; existing service is being reduced or terminated and goals need to be revised, added or terminated; a significant event has occurred in the person's life requiring review of goals, etc.)
    - On or before assigned target dates
    - When a provider changes
- **Introductory PCP**
    - For use **only for a person who is new to the mh/dd/sa system or who has been completely discharged for 60 days with no services.**
    - The Intro PCP consists of:
        - Action Plan page(s)
        - Crisis Prevention/Crisis Response page(s)
        - Signature page
    - The Intro PCP is valid for whatever period of time is authorized for services by VO, after submission of the Intro PCP, usually no more than 90 days.
- **Complete PCP**
    - We are most likely to see only Complete PCPs for residential treatment services.
    - The Complete PCP must be submitted to VO prior to the end of the first authorization period for additional authorization to occur (if initial residential authorization occurred under an Intro PCP).
    - **There may be no separate PCPs** written for residential treatment services.
    - All sections of the PCP are required for the Complete PCP:
        - Participants in Plan Development

        - 3 Interview sections
        - Summary of Assessments and Observations
        - Actions Plan
        - Crisis Prevention/Crisis Response
        - Comments and Signatures

- The Complete PCP must be rewritten annually. This will most often be done at the same time as the annual review for medical necessity.
- Target dates may not exceed 12 months.
- **Signatures:**
    - Author of the PCP and legally responsible person have signed the PCP (documented explanation if not signed or signed later). Signatures must be dated on or before the date of service.
        - Child's signature alone is OK when an emergency admission to 24 hr. facility and the legally responsible person isn't present, and the child is MI or SA and in need of treatment (GS 122C-223(a).
        - Per above, within 24 hrs. of admission, legally responsible person must be notified and unless that notification is impossible, legally responsible person is required to sign the plan [GS 122C-223(b)].
        - Per above, if legally responsible person is not located within 72 hours of admission, responsible professional must initiate protective services and the protective services representative must sign the plan (GS 122C-223).
    - Signatures of the person to whom the plan belongs (or legally responsible party) and the person who wrote the plan are obtained for each required/completed review, even if no change occurred.
    - Signature verifying medical necessity (a service order) is required only if the result of an interim review is the addition of a new service, unless the review is the annual review of medical necessity.
- **Documentation of the legally responsible person, if not the parent of a minor, needs to be reviewed, i.e., court ordered guardianship, court-appointed custody to DSS.**
    - **NOTE: Providers, please ensure you have these documents in your records.**
    - If a minor is cared for by someone other than a parent, and evidence of that caretaker having the intention for long-term care is present, that may be accepted as “in loco parentis” in lieu of legal guardianship.
    - Check with Team Leader before accepting “in loco parentis”.
    - **Ratings:**
        - If PCP is current, rate Q3a = “4”.
        - If PCP is not current**,** rate Q3a = “0”.
        - If Q3a is rated “0”, enter the dates in Q3b. **FROM is the date the PCP was written, or 7/1/09; TO is the date the PCP went into effect, or the date of the audit.**

<u>Q4 – The psychiatric assessment was completed by an independent practitioner.</u>
The auditor will review the record to determine if there was a prior working relationship between the psychiatrist and the provider agency. (Look for evidence prior to the assessment date). Evidence may be seen in signature page for PCP, case

management notes, licensed professional notes, PCP meeting attendance sheets, evaluations, etc.

For individuals in Residential treatment on 9/28/09, a psychiatric evaluation was required for a concurrent authorization (re-authorization when the then current authorization expired). VO would not process the reauthorization without the evaluation. Ask the provider for the evaluation submitted with the re-authorization request.

For individuals who were admitted to residential services after 9/28/09, no psychiatric evaluation was necessary for authorizations from Value Options for the first 120 days. If the individual was in need for additional services after the first 120 days, a psychiatric evaluation was necessary for Value Options to process the request. Ask the provider for this evaluation if the individual is still receiving services after the initial 120 days (even if this is after the date of service audited).

- **Ratings:**
  - If psychiatric assessment was completed by an independent practitioner, rate Q4a = "4".
  - If psychiatric assessment was not completed by an independent practitioner**,** rate Q4a = "0".
  - **FROM is the date first date of the authorization period the assessment relates to; TO is the end of the authorization period or the date of the audit**.

Q5 – The PCP is Individualized

- PCPs and goals/interventions in particular, should be individual to the person to whom the PCP belongs.
- **Rating**
  - **4**=service(s)/support(s), goals, strategies, and interventions in the PCP reflect and are tailored to meet the individual's needs and preferences for **all** service(s)/support(s) listed.
  - **2**=service(s)/support(s), goals, strategies, and interventions in the PCP reflect and are tailored to meet the individual's needs and preferences for **some** service(s)/support(s) listed. Others appear to be written "one size fits all" and reflect program or service requirements rather than the individual's needs and preferences.
  - **0**=service(s)/support(s), goals, strategies, and interventions in the PCP do not reflect and are not tailored to meet the individual's needs and preferences. They are missing or appear to be written "one size fits all" and reflect program or service requirements rather than the individual's needs and preferences.

Q6 – Service Note Relates to Goals:

- Service note reflects purpose of the intervention
- Service note states, summarizes and/or relates to a goal or references a goal number in the current PCP.
- The goal has not expired and is not overdue for review.
- If the goal in the note does not reflect the exact language or use the right number for a goal, review the goals in the PCP to see if it relates to one of them.
- **Rating**
    - **4**=purpose documented in the service note relates to a goal listed in the PCP.
    - **2**=purpose documented in the service note partially relates to a goal listed in the PCP
    - **0**=no purpose included in the note or purpose documented in the service note does not relate to a goal listed in the PCP.

- If the child was on therapeutic leave on the service date being audited, the PCP must include Therapeutic Leave as a goal or strategy which includes the necessity for such leave and the expectations involved in such leave.

Q7 – Service Note Reflects Treatment for the Duration of Service:

- Service note reflects intervention/treatment
    - The intervention relates back to the stated purpose in the service note
    - If the intervention relates to a goal in the plan but it isn't the stated goal on the note, do not call out of compliance, but make a clear comment in the comment section.
- Determine that the documentation provided for a specific date of service adequately represents the number of units paid:
    - Does the intervention/treatment documented justify the amount of time paid?
    - Did the intervention documented reasonably take place in the time documented?
    - Did the intervention reflect "treatment", not activities of daily living (ADLs) unrelated to goals, symptoms and diagnoses, for the time indicated?

Rating

- **4**= the note reflects treatment for the entire duration paid.
- **2**= the note reflects treatment for more than half of the duration paid
- **0**= the note reflects no intervention or treatment for less than half of the duration paid.

Q8 Service Note Reflects Assessment of Progress towards goals:

- **Assessment of person's progress toward goals** / effectiveness for the individual (how did it turn out for the individual; how did the individual respond to the intervention?).

Rating

- **4**= there is a clear indication of the assessment of the intervention
- **2**= there is minimal indication of the assessment of the intervention
- **0**= there is no indication of the assessment of the intervention

Q9 – Service Note is Written and Signed:

- Service note is **written and signed** by the person who provided the **service (full signature, no initials).**
  - "Written" means "composed".
  - If any issues are found, please request the signature log from the provider. The customary signature of the person is acceptable as a full signature and it should match the agency's signature log
- **Signature includes credentials, license, or degree for professionals; position name for paraprofessionals; credentials, license, degree or position may be typed, stamped or handwritten**.
- **Rating**
  - **4**=the documentation is written within the allowed time frame and the signature includes credentials and/or position of the person providing the service.
  - **2**=the documentation is written within the allowed time frame and signature does not include the credentials and/or position.
  - **0**=the documentation is written and/or signed after the allowed time frame or the signature is missing.
- Family members or the legally responsible person may not provide these services for reimbursement.
- If there is **no service documentation for the date being audited**, mark this question "6 = No service note". Also mark "6" for Qs 7, 8, 9. *Do not mark "6" for Q10. Q10 will be evaluated without benefit of a note for the date of service.*

Q10 – Service Notes are Individualized:

- Review service notes around the service date audited to determine if notes are individualized.
- **Notes should vary from day to day and person to person**, and be specific to goals in each PCP.
- The first record audited may have to be revisited if consequent notes in another record appear to be the same.
- **No Xeroxed notes with the dates and/or signatures changed**.
- **No handwritten notes copied throughout the record** with different service dates.

- **Rating**
  - **4**= service note does not match any other service note.
  - **2**= service note is similar but not exactly the same as another service note.
  - **0**=service note is exactly the same as another service note.

Q11 – Licensed Professional Services – for Level III only

- Ask for evidence that **face-to-face clinical consultation** occurred at least 4 hrs/week in the facility by a licensed professional.

- Consultation shall include:
  - Clinical supervision of the Qualified Professional
  - Individual, group or family therapy, or
  - Involvement in child/adolescent specific treatment plan or overall program issues
- **Rate this question NA for Level IV.**
  - **Ratings –** If there is evidence of face-to-face clinical consultation rate Q11a = "4".
  - If there is less than 4 hours of face-to-face clinical consultation rate Q11a = "0".

Q12 – Qualifications/Training:

- Provider of service is qualified in accordance with State rules.
- **If child/adolescent is at risk for sexual offending (look at PCP / goals / diagnoses) special training of the staff is required in all aspects of sex offender specific treatment.**
- The paraprofessional service provider has a high school diploma or GED, and all qualifications are in place on or before the date of service.
- Qualifications not expired.
- Alternatives to Restrictive Interventions training:
  - Auditors will have a list of State approved Alternatives to Restrictive Interventions curricula.
  - Ask what training program the provider uses and compare to list of approved curricula.
  - The initial training or an update must have occurred within one year prior to the date of service being reviewed.
  - In order to consider this training in compliance, **all staff who signed shift notes on the date reviewed** must have received training within one year of the date of service.
- If service note is not signed or missing, rate Q12 as "7/provider name not available".
- **Use the Qualifications Check Sheet included in your audit packet while checking for credentials/training.**
  - For CPR and First Aid, one person working each shift must have the training.
  - If staff reviewed is not trained in CPR or First Aid, determine if any other staff worked and if they had the training.
  - If any staff on shift was trained, do not call qualifications out of compliance.
- **Q12a – Dates:** *FROM* is the first date service was provided when staff was not qualified (or 7/1/09, whichever is later). *TO* is the last date before the staff became qualified or the date of the audit if still not qualified.

Q13 – Supervision Plans:

- Individualized supervision plans are required for paraprofessionals and associate professionals. Plans are to be developed upon hire and reviewed annually. Ensure the plan you are reviewing has been reviewed within the last year.
- **Q13a:** Review each supervision plan to determine frequency/duration of required supervision. If supervision plan is in place, rate Q13a = "4".
- An agency policy on supervision, even if it includes frequency/duration of supervision may not be accepted in lieu of an individual supervision plan.

- **Q13b:** Supervision plans must be implemented as written. Review documentation of supervision against the supervision plan requirements. If supervision plan was implemented as written, rate Q13b = "4".
- Evidence of the implementation of supervision plans could include such things as notes or logs kept by the supervisor of group and/or individual supervision meetings.
- Any documentation accepted must include at a minimum, the name of the staff person and indicate the date of the supervision and the duration of the meeting, if duration is specified in the supervision plan.
- Standard staff meetings are not considered "supervision".
- **Q13c – Dates:** If there is no supervision plan (or no annual review) or it is not implemented as written, enter the dates of non-compliance in 13c, for example:

    - If there is no supervision plan, FROM is the date of hire or 7/1/09, whichever is later, and TO is the day before a supervision plan was in place or the date of the audit. For example: FROM: Oct. 18, 2009 *(date of hire)* TO: April 28, 2010 *(date of audit).*
    - If there is a supervision plan but no evidence it was implemented, enter the dates of non-compliance in 13c. For example:
        - Supervision plan calls for 1/month supervision. Event date is March 12. Enter "*FROM*: March 1 *TO*: March 31, 2010" in 13c.
        - Supervision plan calls for 1/week supervision. Event date is March 12. Ask what the work week is (i.e., Monday-Sunday). Look up corresponding dates for the week and enter in 13c.
    - If there is a supervision plan but no frequency is indicated, the default for audit purposes in one month. Enter the dates of the month for the date of service reviewed. For example, if date of service is 3/25/10, FROM: 3/1/10, TO: 3/31/10.
    - If the supervision plan was not reviewed on an annual basis (plan had expired), FROM is the day after the plan expired (plan expires one year from plan date) or 7/1/09, whichever is later, and TO is the day before a valid supervision plan was in place or the date of the audit.
- **Overall Rating:** Both Q13a and Q13b must be rated "4" to have an overall rating of "4" for Q13.

<u>Q14 – Criminal Record Disclosure and/or Criminal Record Check (CRC)</u>

- **Q14a – Criminal Record Disclosure *for staff hired prior to 3/24/05*:**
    - Determine date of hire.
    - Auditor will request from service provider, any documentation that indicates the agency requested the required disclosure prior to employment.
    - Most likely to see on employment applications, or on documentation from interview.
- **Q14b – Criminal Record Check *for staff hired on or after 3/24/05*:**
    - Determine date of hire.
    - No criminal history record checks required for applicants that have an occupational license, i.e. MSW, MD, Nurse, etc.
    - For an applicant who had been a resident of NC for **less than five (5) years**, he/she must have **consented to a State and National** (national checks

conducted by the Department of Justice with finger prints) record check before conditional employment.
  - For an applicant who had been a resident of NC **for five (5) years or more**, he/she must have **consented to a State** record check before conditional employment.
  - The provider, within five (5) business days of making a conditional offer for employment, must submit a request to the Dept. of Justice to conduct a criminal record check. A NC county or company with access to the Division of Criminal Information (DCI) data bank may conduct the record check on behalf of the provider.
  - **Most often providers will show auditors the actual criminal record check results. HOWEVER, to be in compliance with this requirement the auditor need only see the applicants consent for a CRC or the auditor may see the provider's request for a CRC. We do not need to see the results.**
  - ***For purposes of the audit, the criminal record disclosure or consent to or request for a CRC must have occurred prior to the date of service reviewed.***
- **Q14c – Dates:** If the disclosure or consent or request for Criminal Record Check was not completed prior to the date of service, enter the dates in Q14c. *FROM* is the date of hire or 7/1/09, (whichever is later), *TO* is the last date before the disclosure or consent for the record check was completed, or the date of audit, if not yet completed.

Q15 – Health Care Registry Personnel Check

- There may be **no substantiated finding of abuse or neglect** listed on the NC Health Care Personnel Registry.
- Health Care Personnel Registry check must have been completed prior to the date of service.
- **Q15a – Dates:** *FROM* is the date of the finding noted on the HCPR, the hire date or 7/1/09 (whichever is later) if the check was not completed prior to the date of service. *TO* is the last date before the HCPR check was completed or the date of the audit if not yet completed.

Comment Section:

- Ensure that a good explanation is included in the comment section for any item called out of compliance.
- **Attach copies of documentation to support the findings and the written explanation.**
- Note and make recommendations regarding other PCP or service note deficiencies that are out of compliance with DHHS rules other than the Medicaid required criteria above.

Additional Information:

- Review all tools for completion, accuracy, and attachment of supporting documentation.
- The provider being audited should not leave the audit site with their records before the completed audit tools are reviewed by a Team Leader.

- Make copies of the audit tools for the provider. Let provider know all areas found out of compliance and of any POCs that will be required.
- Remind providers that the copies of the audit tools do not necessarily represent the final, formal results of the audit. Changes could be made after a later Team Leader review or other State findings. Final findings will be represented in the formal Summary of Findings report that they receive by mail and which will be accompanied by any DMA information regarding sanctions.